MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
NOVEMBER 21, 1997 REGULAR BUSINESS MEETING MINUTES

Adopted by the Task Force on January 5, 1998.

Friday, November 21, 1997
8:30am
1201 K Street, California Room
California Chamber of Commerce
Sacramento, California

I. CALL TO ORDER [Chairman Alain Enthoven, Ph.D.] - 8:53 AM

The seventh Business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. ROLL CALL AND DECLARATION OF A QUORUM - 8:55 AM

The following Task Force members were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Dr. Donna Conom, Ms. Barbara Decker, Mr. Alain Enthoven, Ph.D., Ms. Nancy Farber, Ms. Jeanne Finberg, Hon. Martin Gallegos, Dr. Bradley Gilbert, Ms. Diane Griffiths, Mr. Terry Hartshorn, Mr. Bill Hauck, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Dr. Helen Rodriguez-Trias, Mr. Les Schlaegel, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. David Tirapelle, Mr. Ronald Williams, Mr. Allan Zaremberg, and Mr. Steve Zatkin.

Chairman Enthoven announced that a quorum was present.

The following Ex-Officio Members were also present: Ms. Marjorie Berte, Mr. Michael Shapiro, Dr. David Werdegar.

III. OPENING REMARKS [Chairman Alain Enthoven] – 9:00 AM

Chairman Enthoven began the meeting with a few housekeeping details. Specifically, he announced that the October 28, 1997 Adopted Risk Adjustment Findings and Recommendations Section was included in members' manila folders and that copies were also available to the public. He stated that members would be asked to work through the lunch hour in order to complete the business of the day. Pre-ordered lunches would be delivered at approximately 12:30pm. The Chairman also referenced a proposed time scheduled of the business of the November 21, 22 and 25 meetings faxed to members a few days ago.

Chairman Enthoven said that given the amount of work before the Task Force, he would appreciate members complying with the proposed time schedule, and asked members to

serve as “time keepers” to ensure discussions on papers do not exceed the time allotted to them.

Understanding that time is constrained given the Task Force’s January deadline to submit its report, Chairman Enthoven requested that members who have additional, written comments on papers discussed November 21 and 22 to submit those comments to his staff by November 25. Members wishing to submit additional, written comments on papers discussed November 25 will be asked to submit their comments to his staff by November 26. Staff will work through the Thanksgiving holiday to ensure papers are inclusive of comments provided by members and ready for mailing to members on December 2 [for the December 12 and 13 meetings].

Several members indicated their concern that the time frame outlined above was too constraining, however, the Chairman reiterated the Task Force’s report deadline and that because of that deadline, members are being asked to comply with the proposed schedule.

Ms. O’Sullivan then questioned whether the Task Force report would continue to sport a prominent statement that several important issues were not considered by the Task Force due to time constraints, but that did not equate that these issues were any “less” important than the issues addressed by the Task Force. Chairman Enthoven assured Ms. O’Sullivan that such a statement would be included in the report and that this issue could be discussed later this morning.

Ms. O’Sullivan also proposed that nothing be included in the Report’s First Volume [Main Report] that was not adopted by Task Force members and that all background papers be included in the Second Volume [Appendices].

After discussion as to whether documents adopted by the Task Force will be included in the report verbatim [without staff alterations], Ms. Alice Singh, Deputy Director for Legislation and Operations indicated that it is the intent of this body and its staff that once a paper [or Findings and Recommendations Section] is adopted by the Task Force, the only changes that can be made to that document by staff are formatting, grammatical and other purely technical changes.

Chairman Enthoven then turned to the subject of the Chairman’s letter saying that if members are too constraining in the development of his letter, he will simply sign a letter that says something like - here is the report…-. He would then include his own, personal statement in the report just as other members may do. Ms. O’Sullivan suggested the Chairman’s letter be about process and not substance.

Ms. O’Sullivan requested that the Vulnerable Populations paper be discussed today as opposed to tomorrow. Chairman Enthoven responded by stating that the order of business was established pursuant to a Delphi Questionnaire on priorities sent to members about a week ago.

Mr. Williams expressed his concern that members do not have sufficient time to wordsmith each paper and that instead, members should focus their efforts on the recommendations proposed in each paper. Chairman Enthoven agreed.

Mr. Shaperio asked about the economic evaluation of the recommendations to be drafted by Executive Director Romero. Executive Director Romero responded that he would address this issue in his report to the Task Force this morning.

Chairman Enthoven then commented briefly on the revised draft of the Consumer Choice paper that was distributed to the members. Because of the amount of comments that were received regarding this paper, staff felt it was necessary to create a revised version in a line-in/line-out format. He asked members to review the line in/line out version during lunch so that it could be addressed later that afternoon.

He also discouraged members from introducing new topics for inclusion in the Report, due to the fact that staff would not have the time to study and consider them properly. He proposed that a chapter be created in the Report, entitled "Unfinished Business", for precisely those ideas or comments. He further encouraged members to submit their language for inclusion in this section to his staff by November 25.

A short discussion was held by members regarding some of the members meeting in groups to discuss the finalization of the report and/or minority reports/letter. Pursuant to a request from members, Ms. Singh clarified that the Open Meetings Act allows no more than two members to meet to discuss ideas without such a meeting[s] being publicly noticed.

Chairman Enthoven then turned to the Report transmittal statement stating that he will propose a series of statements to be used to transmit the Report to the Governor and the Legislature, and that members would be asked to adopt the "most positive" statement. The adoption of the Report transmittal statement will be scheduled for the January 5, 1998 meeting.

Lastly, Chairman Enthoven introduced the newest Task Force member, Les Schlaegel. Mr. Schlaegel was appointed by the Governor to replace Katherine Murrell, who had retired a few months ago.

A. Executive Director's Report [Phil Romero, Ph.D.] - 9:40 AM

Executive Director Romero spoke about the economic impact of the Task Force recommendations. He characterized this impact into three categories: spending, trust and the scope of government. He stated that he could have estimates ready for the members review by the December meetings but his recommendation would be to not publish a formal economic impact assessment as a component of the Report. Chairman Enthoven agreed with Executive Director Romero's recommendation and suggested that an additional "disclosure statement" should be included in the Report stating that the Task Force was not able to cost out each recommendation due to time and staffing constraints.

Mr. Shapiro warned of potential criticism the Task Force may face if a cost analysis is developed too quickly and without members input. Executive Director Romero responded stating that perhaps it would be appropriate to take a straw pole vote on the desirability of effort to establish such a cost analysis before the January 5, 1998 meeting. Ms. Griffiths echoed Mr. Shaperio's comments.

Dr. Spurlock suggested using the Delphi process to prioritize each adopted Task Force recommendation.

Executive Director Romero concluded his report by stating that without objection, he would think about the cost analysis of each recommendation on "a background basis", and instead, devote his time to the more qualitative prioritization efforts Dr. Spurlock suggested.

He may have more time to prepare a cost analysis of the adopted recommendations after January 5, 1998, but cautioned that such an analysis would not be published under Task Force auspices. No objection was stated.

Chairman Enthoven then moved to the next report.

1. Presentation of the Public Survey Results [Dr. Helen Schauffler] - 9:55AM

Executive Director Romero introduced Mr. Mark DiCamillo of Field Research Corporation and Mr. Lee Kemper of the California Center for Health Improvement (CCHI), who both worked on the public survey. Executive Director Romero stated that the survey was still in the field going through the last round of interviews. He also said that two formal products will be produced for the Task Force members, one for inclusion in the final report and one more reader-friendly version produced by CCHI. Most of the survey results had not yet been released in order to curb any bias that might result in the remaining interviews. Also, Executive Director Romero mentioned the California Health Care Foundation, the Robert Wood Johnson Foundation and the Institute for Healthcare Advancement, all of whom contributed financially to the production of the survey.

Dr. Schauffler stated that the objective of the survey was to document the extent to which Californians report having experienced a problem with their health plan in the last year, which problems they were reporting, how severe the problems were and differences in the problems by managed care model type. The survey was conducted in the form of a telephone interview with phone numbers being chosen at random. There were three separate samples done, all of insured, adult Californians. The first dealt with the general insured population; the second dealt with insured, adult Californians who were dissatisfied or very dissatisfied with their health plan; the third sample, which had not yet been completed, includes persons who have a serious or chronic illness.

The survey found that 76 percent of the population overall were satisfied or very satisfied with their health plan, with about 10 percent being dissatisfied or very dissatisfied. Satisfaction with the healthcare system as it relates to their families was lower. The percentage who said they were satisfied with the health care system was almost half the rate of those who reported being satisfied with their plan. Similarly, the dissatisfaction rates with the health care system were almost double the health insurance plan dissatisfaction rates.

The survey also tracked the satisfaction rates by type of managed care plan. Three models were looked at: group/staff model HMOs, IPA/network model HMOs and PPOs. Persons in the IPA/network model were less likely to be very satisfied with their plan compared with the group/staff HMO. Similarly, persons in IPA/network plans were significantly more likely to be dissatisfied with their plan compared to both group/ staff HMOs and PPOs.

Californians were also asked whether or not they have had a problem with their health plan in the last year. It was found that 42 percent or 6.7 million people have reported some problem with their plan in the last year. The list of thirteen problems reported were listed in five categories: coverage, claims and payments, care and service, choice, and accessibility. Dr. Schauffler reviewed the prevalence of each of the problems, including: 13% said they had had problems with billing or payment of claims or premiums; 11% said

that they did not receive the most appropriate medical care or the care they needed; 10% stated that there were delays in getting their medical care; 10% had difficulties getting referrals to specialists; 11% said health care providers were not sensitive to their needs or were not helpful; 8% said they had had difficulty in selecting a doctor; 7% were forced to change their doctor; 4% were forced to change their medications; communications difficulties were reported by 5%; and transportation problems were reported by 4% of the general insured population.

Dr. Schauffler stated that the results show a direct linear relationship between the likelihood of having had a problem with your plan and how satisfied you are with that plan.

Californians were also asked about their overall view of the health care system and the extent to which they feel it needs to be changed. Approximately 84 percent, or 13.4 million people, want some sort of change. This change falls between minor changes to a complete overhaul. Again, a strong linear relationship is found between the desire for change in the health care system and the likelihood of having had a problem with one's plan in the last year.

The survey also looked at the different types of problems reported by people in different types of managed care plan. The survey found that Californians in IPA/network model HMOs were significantly more likely to have difficulty in getting referrals to specialists and selecting a doctor or hospital, compared to those in staff/group model HMOs or PPOs. Californians in IPA/network plans were also more likely to report problems with the plan not covering important benefits, misunderstandings over benefits or coverage, not getting the most appropriate care, and being forced to change doctors. In the group/staff HMO model, transportation problems were significantly more likely. People in PPOs were more likely to have problems with billing and payment of claims or premiums, their plan not covering important benefits, and misunderstandings about benefits or coverage, compared to those in staff/group model HMOs. There were also a number of problems that showed no significant differences between the models which suggests that these problems were really systemic difficulties and not a function of the organization of care.

Californians were also polled about the health impacts of the problems they reported with their plans. 13% of insured, adult Californians said that because of their problem, they experienced pain and suffering longer then they should have. 6% said their problem led to other health conditions that were not previously present. 9% said their problem led to the worsening of their health condition. 2% of insured, adult Californians reported that their problem with their health plan in the last year led to a permanent disability and affected their daily living activities.

Dr. Schauffler wanted to make sure that the Task Force members were presented with information regarding the importance of choice to Californians. 81% of those surveyed stated that having the choice of more than one plan was important or very important. However, 23% were offered only one plan and 41% were offered only one or two plans. This is significant because people who had the choice of only one or two plans were significantly more likely to experience a problem with their plan compared to people who had the choice of three or more plans.

The survey also polled people about whether their problems had ever been resolved. 57% of those who had a problem said that they had tried to resolve their problem, with 4% stating

they had contacted a state or local agency for assistance. Over half (52%) said that their problems had been resolved while 42% said that their issues had not yet been resolved.

The survey also asked about satisfaction with the handling and resolution of complaints. Only 11% of those who had a problem were very satisfied with the way their health plan handled their complaint, 28 percent were satisfied, 18 percent were dissatisfied and 11 percent were very dissatisfied. Only 6 percent of those whose problems were resolved said the resolution exceeded their expectations, while 40 percent said their problem was solved satisfactorily. About 32 percent said they were not completely satisfied and 12 percent claimed they were not satisfied at all.

Several members had questions regarding the survey results. Mr. Gallegos asked if problems with the plans were solved through an internal process. Dr. Schauffler indicated that the majority of the issues were solved inside the plan. He also asked if any Medi-Cal or Medicare people were included in the surveys, which Dr. Schauffler said there were. Dr. Werdegar asked wanted to know what language the surveys were done in. They were conducted in both English and Spanish.

IV. CONSENT ITEMS – 10:36 AM

Chairman Enthoven introduced the next order of business, the adoption of the Consent Items. The only consent item was the proposed August 7, 1997 meeting minutes. Vice Chairman Kerr moved to adopt the Minutes, with minor changes [add Ms. Berte's name to the list of August 7 meeting attendees and to delete Ms. Griffiths' name from that list. Mr. Lee seconded the motion which was unanimously adopted by the Task Force.

V. ACTION ITEMS – 10:40 AM

A. Discussion/Adoption of Proposed Amendments to Standing Rule #4

Ms. Singh introduced the next order of business - to adopt Standing Rule No. 4.5 which was composed of five amendments.

Amendment No. 1

Amendment No. 1 listed and described the three components of the Report to be prepared pursuant to AB 2343 [Ch. 815, Stats. Of 1996]: I. Executive Summary, II. Main Report and III. Appendices. Amendment No. 1 was moved for adoption by Mr. Rodgers and seconded by Dr. Spurlock. Mr. Lee then moved to delete the list of and information pertaining to managed care issues not addressed by the Task Force as a component of the Main Report. Mr. Perez seconded the motion and it was adopted with 21 affirmative votes. Discussion then stemmed to include in the Executive Summary a statement indicating that the Task Force members were unable to address all issues surrounding managed care, but that does not equate that those issues any less important.

Members then discussed the option of including those letters [or minority reports] written by members re: issues addressed in the Report in the Main Report. Mr. Hauck then moved to include those letters [or minority reports] written by members re: issues addressed in the Report in the Main Report. Mr. Lee seconded the motion and it was adopted with 21 affirmative votes. Ms. Singh then reiterated that all such letters must be submitted to her by noon on December 19 to ensure their inclusion in the January 5, 1998 meeting packet.

Mr. Perez then moved to substitute the word “may” with the word “shall” and deleting the phrase “but not limited to” regarding the composition of the Report prepared pursuant to AB 2343. Ms. O’Sullivan seconded the motion and it was adopted with 22 affirmative votes.

After some discussion, Ms. O’Sullivan then moved to substitute the phrase “the full papers that are required by AB 2343” with “the Findings and Recommendations Sections of those papers that are required by AB 2343.” Mr. Perez seconded the motion and it was adopted with 22 affirmative votes.

Mr. Perez called for the question on the main motion to adopt Amendment No. 1, as amended. The main motion was adopted with 22 affirmative votes.

Amendment No. 2

Amendment No. 2 stated that the individual components of the Main Report must be adopted by the Task Force. Mr. Perez made a motion adopt Amendment No. 2 up to and ending with the sentence ending with “set forth in Standing Rule No. 4”. Mr. Lee seconded the motion which was adopted with 18 affirmative votes.

Amendment No. 3

Amendment No. 3 stated that the Executive Summary did not require adoption by the Task Force. Mr. Perez moved to adopt Amendment No. 3 with the following revisions: delete the words “does not” and change the word “require” to “requires” to in essence, require Task Force adoption of the document. This motion was seconded by Ms. O’Sullivan. Chairman Enthoven responded to this motion by stating that he wanted the members to understand exactly what they would be voting for and what a vote would likely do to the end report. Dr. Rodriguez-Trias and Ms. Decker responded that they were in favor of the members reviewing the Executive Summary, given its importance. Mr. Perez made another motion insert the words “as to form and content” after “Task Force”. The motion was seconded by Mr. Lee and adopted with 23 affirmative votes.

The Main Motion to adopt Amendment No. 3, as amended, was adopted with 23 affirmative votes.

Amendment No.4
Amendment No. 4 provided that the Report Appendices do not require Task Force adoption. Ms. Bowne moved adoption of Amendment No. 4 and it was seconded by Mr. Rodgers. Mr. Lee clarified that all documents that are included in the report should be made available to the members for review only and not for voting. Members then adopted Amendment No. 4 with 22 affirmative votes.

Amendment No. 5
Amendment No. 5 stated that the members would vote on language that would be used to transmit the final report to the Governor and the Legislature. Chairman Enthoven moved to remove language in the amendment that would create any ambiguity about the January 5 deadline. Mr. Rodgers moved to adopt this amendment which was seconded by Dr. Rodriguez-Trias. Members had a discussion about this change and whether it would limit them in their ability to call for additional meetings of the Task Force if they were needed. Members adopted the proposed amendment with 22 affirmative votes.

Members then adopted Amendment No. 5, as amended, with 22 affirmative votes.

Recess – 11:50 AM

B. Adoption of the Standardization of Benefit Paper's Finding & Recommendations Sections – 12:05 PM

Public Comment:

1. **Maureen O'Haren**- California Association of Health Plans.Ms. O'Haren was concerned that the reference packages were being recommended for the individual and small group markets outside of purchasing groups. She felt that reference packages would be best for large employers and new purchasing groups. She was also concerned that the recommendations would lead to the reference packages being required in the marketplace, which would stifle innovation.

Task Force Discussion:

Ms. Bowne asked that the title and Recommendation 1 be changed to refer to standardized benefit format and terminology rather than standardized contracts. She also asked for clarification in Recommendation 2 that the reference contracts are optional and not required. Dr. Karpf, Dr. Gilbert, Mr. Williams, Mr. Zatkin, and Mr. Hartshorn agreed with Ms. Bowne. Mr. Ramey disagreed, stating that the contract is the only enforceable part of the transactions between the consumer and the purchasers and if it was removed the whole paper would become invalid.

Ms. Decker felt the items in the recommendations didn't seem to fit together and would not be possible to adopt as a whole. Ms. O'Sullivan agreed and recommended keeping the contract language in the paper.

Mr. Shapiro asked whether the Task Force shouldn't just use the standard models that CalPers, PBGH and HIPC already had available as reference packages. He stated that no one had to necessarily sell or buy these materials, but they could be used simply as a comparative tool for the buyers.

Both Dr. Rodriguez-Trias and Mr. Rodgers agreed that there is a need to separate what the consumer needs to evaluate a plan and what the employer requires to have an understanding of what is in their contract. They thought that these two issues should not be together in the same recommendation. The issue of whether certain language in the recommendation could be construed as misleading to the consumer was addressed by Dr. Northway and Ms. Finberg. Ms. Finberg stated that she feels standardization is very critical for consumers and argued to keep the word "contracts" in the recommendation.

Voting:

Recommendation No. 1

Ms. Farber moved to adopt Recommendation No. 1 as amended to read: The Governor and the Legislature should direct the state agency [or agencies] that is [are] charged with regulating managed care to adopt a proactive policy towards the development of standard coverage models that emphasize clarity of language and structure of benefits in order to enhance comparability by purchasers and consumers. Mr. Williams seconded the motion and the motion failed with only 10 affirmative votes.

Mr. Perez then moved to adopt Recommendation No. 1, as originally proposed with minor changes proposed by Chairman Enthoven. The Chairman seconded the motion and Recommendation No. 1, as amended, was adopted with 19 affirmative votes.[1]

Recommendation No. 2(a) through (d)

Mr. Perez moved to adopt Recommendation No. 2(a) through (d) as proposed. Ms. Finberg seconded the motion which was adopted by the Task Force with 19 affirmative votes.

[1] Recommendation No. 1, as adopted, reads "The state entity(ies) for regulation of managed care should be directed to adopt a pro-active policy toward the development of standard reference health plan contracts that can be used by buyers and sellers by reference, that health plans can offer on a fast track basis through the regulatory process."

Recommendation No. 2(e)

Mr. Perez moved to adopt Recommendation No. 2(e) with the amendment that "or" be substituted with the word "and" regarding the required publishing and providing plan comparisons to employers and consumers. Ms. Finberg seconded the motion which was adopted 16-7.

Recommendation No. 3

Mr. Lee moved to adopt recommendation 3 as originally proposed. Mr. Perez seconded the motion. After some discussion, several informal, technical amendments were accepted without objection. Recommendation No. 3 was adopted with 20 affirmative votes.[2]

Findings Section

Mr. Perez moved to adopt the Findings Section, as proposed. Vice Chairman Kerr seconded the motion and it was adopted with 20 affirmative votes.

Lunch Break – 1:20 PM

E. Adoption of the Health Industry Profile Findings Section – 2:00 PM

The Chairman stressed that he and his staff had taken great efforts with the Health Industry Profile paper to incorporate the views of all members. Notably, all references to any managed care corporation had been removed. The Chairman stressed that pursuant to the adoption of Standing Rule No. 4.5, only the Findings Section of this paper would be put to a vote.

The discussion proceeded and Vice Chairman Kerr moved to adopt the Findings Section of the Health Industry Profile paper and Mr. Rodgers seconded the motion.

Dr. Karpf asked that the paragraph about medical loss ratio that was in the body of the report also be included in the executive summary. The Chairman asked if there was any objection to this technical amendment - no objection was made. Thus, the amendment was accepted.

Ms. O'Sullivan was concerned that the information about the MediCal issue that was discussed in the paper required updating. She also wanted to add the fact that millions of MediCal beneficiaries were being transferred to managed care. To accommodate Ms. O'Sullivan's concern, the Chairman proposed, without objection, to add on page 3 in the

[2] Recommendation No. 3, as adopted, reads, "(a) The state entity(ies) for regulation of managed care should be authorized and directed to convene a working group to develop a standard outline and definitions of terminology for evidence of coverage (EOC) and other documents to facilitate consumer comparison and understanding.
(b) The working group should include the major stakeholders and should build on previous accomplishments by organizations such as the California Public Employees Retirement System, Pacific Business Group on Health, and the Health Insurance Plan of California. The regulatory entity should convene the working group on a biennial basis to consider modifications.
(c) When consensus has been achieved, the regulatory entity should promulgate proposed rules for consideration and adoption, subject to notice and comment proceedings."

paragraph entitled “Purchasers”,”…In 1994, government sponsored programs such as MediCare and MediCal accounted for about 41% of California’s total health care expenditures of $105.3 billion. MediCal is moving increasing numbers of members to managed care with some illustrative numbers…”. No objection was made and the amendment was accepted.

Members adopted the Findings Section, as amended, with 23 affirmative votes.

D. Adoption of the Managed Care’s Impact on Quality, Access & Cost Findings [2:12 PM]

Public Comment:

1) **Catherine Dodd**- American Nurses Association (California) She wanted the Task Force to know that since the penetration of managed care and the downsizing of skilled nurses, there had been a dramatic change in quality in hospital care. As managed care replaced skilled nurses with unlicensed personnel, the skill mix went down in order to meet the cost demands.

2) **Beth Capell**- Health Access Her organization had some major concerns with this paper, especially the fact that the findings rely heavily on studies paid for by the American Association of Health Plans. They also thought that the paper was internally contradictory and contradicts other Task Force papers.

Task Force Discussion:

The Chairman then members to commence their discussion on the Findings Section of this paper. Ms. Bowne asked that wording other than “pharmaceuticals” be used, the reason being that outpatient drugs are not a Medicare covered benefit. She suggested using the words “health prevention and promotion” or “prevention and health promotion”. Dr. Alpert suggesting changing the wording in the opening sentences to read “some change is good and necessary; change however is sometimes uncomfortable”. Mr. Perez added that he thinks using the word “negative” is not necessarily a bad thing. He thought it should be reflected to make the statements equal. Vice Chairman Kerr finally resolved this issue by suggesting deleting most of the paragraph that dealt with this positive/negative issue of change [delete the last three sentences of I. Introduction on Page 1]. There was no objection to Vice Chairman Kerr’s suggestion, thus is was accepted by Chairman Enthoven.

Ms. Bowne then moved to adopt the Findings Section with the above technical amendment and it was seconded by Dr. Karpf.

Ms. Finberg stated that she felt the paper did not go far enough in describing the impact of managed care on quality, access and cost from a consumer perspective. She did not feel that she could vote for the paper as it stood.

Dr. Alpert then moved to amend the motion to remove the word “continuity” [in the bottom paragraph on Page 1] and the words “rewarding quality” [in the continued sentence on the top of Page 2]. He felt both these words were being used in the context that they were directly attributable to managed care. Dr. Karpf seconded this motion. The amendment was adopted with 22 affirmative votes.

Both Dr. Northway and Ms. Bowne felt that there has been a decreased amount of charitable health care given to those who are uninsured. Given that the employment rate is at the lowest point it had been in a while, it is disappointing that the uninsured rate is still rising.

Ms. O'Sullivan made a motion to delete the line on Page 2 that read "lower HMO premiums mean more people can afford health care". She felt this was a misleading sentence and it sounded like people could now afford health care who couldn't have done so before due to slower cost increases. Dr. Conom seconded the motion. Chairman Enthoven spoke in opposition to this amendment and he cited examples of data that prove the statement in question was correct. Members discussed the pros and cons of deleting the statement. Ms. Farber agreed that the numbers of uninsured were growing and she cited several examples of that happening here in California in the Silicon Valley.

Mr. Lee moved to end debate on this issue. A two-thirds vote was needed to call the question. The motion failed.

Vice Chairman Kerr moved to substitute Ms. O'Sullivan's amendment with the following language to read "lower HMO premiums keep coverage affordable for more people". The motion was seconded by Ms. Decker and adopted with 23 affirmative votes.

Ms. O'Sullivan moved to move the language that deals with uncompensated care on Page 22 of the background paper to the 3rd paragraph on Page 2. Ms. Bowne seconded the motion. The motion failed 9-11.

Dr. Northway then moved to amend the first sentence in the 3rd paragraph by adding after "Despite lower overall costs generally…" "as the number of uninsured continues to be high". Dr. Spurlock seconded the motion. Chairman Enthoven asked whether any member had data about a population survey that would show the actual number of uninsured people. Mr. William's felt that the data would show that California would have a large population of uninsured compared to other locations. The motion was adopted with 25 affirmative votes.

Members then adopted the Findings Section, as amended, 16-4.

Break – 3:05 Pm

C. Adoption of the Expanding Consumer Choice Findings & Recommendations Section 3:30 PM

Public Comment:

1) **Conni Barker**- California Psychiatric Association.Ms. Barker pointed out the that the doctor/patient relationship discussion in the paper did not discuss continuity of care if a doctor is removed from a panel. She asked that the Consumer Choice paper and Doctor/Patient Relationship papers be cross-referenced.

2) **Maureen O'Haren**- California Association of Health Plans. Ms. O'Haren was concerned with the recommendations about participation requirements in the small group market, which she felt would lead to adverse selection that could not be sufficiently compensated by risk adjustment. She was also concerned with the potential amendment that would require every HMO to be a point of service plan. She felt this recommendation would actually eliminate choice of plan types from the market place.

3) **Richard Figueroa**- Senate Insurance Committee. Mr. Figueroa argued for expanding the market reforms for the small group market (2-50 employees) to the mid-size (51-100 employees) market. He also argued for individual-market reforms. He supported proposed amendments that had already been made by Mr. Shapiro but were not incorporated into the Choice paper.

4) **Jeanette Morrow**- California Coalition of Nurse Practitioners.Ms. Morrow commended the Task Force on changing the language in the choice paper to read provider/patient instead of physician/patient.

5) **Anne Eowan**- Association of California Life and Health Insurance Co. Ms. Eowan was concerned with the recommendations regarding minimum participation requirements and their potential to create adverse selection for plans. Regarding reforms in the 51-100 employee market, she stated that those employers had not requested the reforms because they are already able to negotiate their own benefit plans. She felt the recommendation would lead to less choice and to more self-insured plans.

6) **Beth Capell**– Health Access. Ms. Capell voiced support for the Senate Insurance Committee suggestions regarding the individual market and the market for mid-size (51-100) employers. She urged the members to consider the implications of the ERISA recommendation very carefully because without an employer mandate, ERISA reforms might lead to fewer employers offering coverage.

The members began discussing the Findings and Recommendations Section. Dr. Karpf asked the Chairman if the members could consider some issues that were not in the paper. Some of his suggested issues were point of service, and choice relating to how much a consumer is willing to pay to get a better range of choice. Executive Director Romero made a suggestion that the members not recommend a mandate on this issue that is not fully developed, but rather suggest a study or further work be done on the idea. Ms. Finberg asked what the percentage of people in the state are who have a point of service option. Ms. Singer stated that she believed it was eight percent with the point of service and another 23 percent with PPO.

Recommendation No. A.(1)

Mr. Perez commented, regarding the recommendation to change ERISA, that he would not vote on an issue that would offer less choice by pricing out the employer. Ms. Bowne said that until the issue of more choice becomes mandated or there is some structural change in the system, the employer will not offer more choice to the consumer mainly because of the issue of cost. Mr. Williams stated that he felt the more choice is offered, the more it seems to be diminishing. The more people that have access to health care, the more people seem to come forward who have no health care at all. Mr. Shapiro stated his opinion that there is a problem in the market place that can be solved with choice. He thinks that there are certain risks associated with choice, but the question becomes, do you promote choice given those risks or do you not, saying the risks are too great.

Executive Director Romero compared the discussion points with some of the information in the public survey. Mr. Perez thought that it is unreasonable to put the burden of offering choice on the employer by mandating the issue. He stated there are additional costs other than those borne by the employee. There are administrative costs that will have to be covered by the employer. Mr. Zaremberg agreed with these statements and added that when you raise the costs you run the risk of reducing access.

Mr. Lee suggested a technical change to the language and Mr. Perez made a suggestion to delete some of the language. Basically, Mr. Perez wanted to strike any reference to ERISA in creating mandates for employers to offer more choice. An informal straw vote was taken on both these revisions. The vote on Mr. Lee's revision received 7 votes and Mr. Perez's revisions received 16 votes.

Mr. Perez then made a motion to delete Recommendation No. A.(1). Dr. Spurlock seconded the motion. Mr. Zaremberg made the observation that the point of contention seemed to be mandating the employer to provide more choice. He thought the Task Force might be feeling frustrated because the Congress is in a better position to deal with the issue. The motion was adopted with 22 affirmative votes.

Recess – 4:35 PM

Recommendation A.(2)

The second recommendation stated that the state would prohibit plans from setting minimum participation requirements for participation in their plans. The intent was that the recommendation would only be implemented to the degree that negative consequences can be avoided. Ms. Bowne wanted to make sure the members understood what the current federal law requires. The law that was passed in 1996 requires all carriers who serve the small group market to guarantee issue of their products to all small employers. Further, once the plan contracts with an employer, it must take anyone and their dependents who elects coverage. Chairman Enthoven asked that the members take a straw poll to determine whether they wanted to discuss this section of the paper. Before the straw poll could be taken, Ms. Bowne moved to delete Recommendation No. A.(2). The motion was seconded by Mr. Williams and adopted with 16 affirmative votes.

Recommendation No. B.(3)

Mr. Hauck moved to adopt Recommendation No. B.(3) as proposed and Mr. Perez seconded the motion. The motion was adopted with 24 affirmative votes.

Several members made suggestions to hold off on all discussions of choice until the meetings in December. However, a majority of members chose to move on to the alternative recommendations.

Alternative Recommendation No. 1

The first alternate recommendation concerned guaranteed issue, plan design, disclosure, and premium rating limitations for employers with 51 to 100 employees so that purchasing cooperatives can form in the mid-sized market. Ms. Decker made a motion to adopt this recommendation and it was seconded by Vice Chairman Kerr.

A discussion on this recommendation started with Mr. Zaremberg asking what the consequences were of this recommendation once rate bands and guaranteed issuance were applied. He asked if the consequences would be the same as those seen in the small group market. Mr. Williams felt that there would be less choice - fewer PPOs - and more self-insured employers if this were adopted. Mr. Zaremberg mentioned Mr. Kritchlow, who had spoken to the Task Force at one of their meetings, and who was in the process of starting a purchasing pool for medium sized businesses without the benefit of rate bands. He wanted to know whether it is better to have 51 to 100 employers in a purchasing pool like Mr. Kritchlow's or have them in the HIPC.

The members ended their discussions and adopted Alternative Recommendation No. 1 17-4.

Alternative Recommendation No. 2

They moved on to alternate recommendation No.2, as submitted to staff by Mr. Shapiro. This recommendation calls for the legislature to enact a law that increases consumer choice by allowing individuals to purchase coverage through purchasing cooperatives. Mr. Shapiro asked that the discussion recognize that these reforms can't be made unless certain market reforms to mitigate the risk are also passed. He suggested the second recommendation be modified to include the mitigation requirements.

Chairman Enthoven had a number of comments about this recommendation. He first wanted to stress that this is not a managed care issue. It is a broad health issue that exists with or without managed care. He had facts that premiums were on the rise due to adverse selection, which has to be paid for somehow in the market. Mr. Shapiro asked that consideration of recommendation No.2 be withdrawn.

Alternative Recommendation No. 3

Chairman Enthoven moved on to alternate recommendation No.3, which would enable agents and brokers to establish purchasing alliances through the Department of Insurance (DOI), but incorporate provisions to track and prevent risk selection. No member claimed ownership of this submittal so the Chairman moved on to recommendation No. 4, submitted by Vice Chairman Kerr.

Alternative Recommendation No. 4

Recommendation No. 4 stated that DOI would be responsible, through brokers and agents, to track and report and improve by 20 percent per year the proportion of employer clients who offer a choice of health plans. Mr. Lee suggested a technical amendment to the recommendation. He asked that DOI require agents and brokers to submit yearly reports and the DOI should do a summary report on the status and in two years time, decide whether it should be mandated or not. Mr. Williams asked how this amendment would affect the agents' fiduciary obligations to the employer. Mr. Lee stated that the amendment does not affect that issue. Dr. Karpf moved to adopt this amendment and it was seconded by Mr. Perez. The members then voted on recommendation No.4 as amended and it failed 6-11.

Alternative Recommendation No. 5

Alternate recommendation No. 5 concerned a closed panel HMO product contract that gives a consumer access to indemnity coverage after a deductible is met. Dr. Rodriguez-Trias made a motion to adopt this recommendation and it was seconded by Vice Chairman Kerr. Dr. Alpert was concerned that this recommendation would cost significantly more money. He advocated making this option available only to persons with life threatening or life disabling conditions and with the condition that the provider agrees to be paid in the same way the plan would have paid its own provider. Dr. Spurlock also liked the intent of the proposal and suggested that it be tied to dispute resolution. However, he was concerned that this recommendation would actually diminish choice for those people who are satisfied with their current HMO plan with no point of service (POS) option.

Mr. Hartshorn felt that people like choice but what they really want is control - control to change doctors. Ms. Decker wanted to point out that that surveys have shown that people in POS plans are the least satisfied with their plans. They have the option of opting out and they give their plans the worst ratings. Mr. Zatkin pointed out that to carry out this opt out idea would end up costing the consumer additional funds and that would not be fair to those in the plan who were satisfied with the program. Chairman Enthoven stated that he would vote against this recommendation because he feels very strongly that people should be provided the opportunity to purchase good quality care at a reasonable price.

Vice Chairman Kerr made several suggestions to make this more appealing. First, you would have restrictions on why you would opt out. Only the most important, critical issues would be covered. Second, the providers you opt to go to would have to prove they would be able to provider better services than those in the plan that the person left. And third, the consumers would have to agree that they were going to opt out.

Mr. Perez moved to defer this recommendation until the December meetings. Ms. Bowne seconded this motion. Members adopted the motion to defer with 19 affirmative votes.

VI. DISCUSSION ITEMS

A. Discussion of the Provider Incentives Paper – 6:00 PM

Chairman Enthoven began the discussion of the Findings and Recommendations Section of the paper entitled, "Financial Incentives for Physicians in Managed Care". He decided

that the other three agenda items would be address at tomorrow's meeting. Mr. Shapiro also asked that any public comment on the paper be at the end of the discussions, if any time remained, given the amount of material still to cover in a short time span. The Expert Resource Group gave a very brief discussion of the findings in the paper. Mr. Zatkin highlighted a few of the items that reflected the previous Task Force discussions on this paper. First, all compensation arrangements contain incentives that can have positive or negative effects and there can be an infinite number of these arrangements. The second is that there is no evidence showing a relationship between specific financial arrangements and adverse outcomes. Of particular concern are incentives which place an individual or small group of health group practitioners at risk for the cost of referrals for their patients.

The ERG members recommended that health plans be required to disclose to the public the general methods of payment made to contracting medical groups in the types of financial incentives used. They recommended that this be done in clear and simple language that is easy for the consumer to understand. They also recommended a pilot project with medical groups to develop a method for disclosure and they asked that all provider groups and health practitioners be required to disclose their method of compensation and incentives paid to their subcontracting providers. The fourth recommendation was a prohibition of certain intense incentive arrangements for individual physicians, including captivation arrangements that include the cost of services for that practitioners patients. Lastly, they recommended stop loss protection for all physicians under these circumstances.

Several of the members asked Mr. Zatkin to clarify some of the language in the recommendations. Dr. Gilbert asked if there was a difference between incentives tied to individual decisions versus total decisions over time. Mr. Zatkin stated that the individual is at risk for the cost of referral for that practitioner's patients. The members had a short discussion about the Department of Corporations and their review process as it relates to small groups. Staff said that DOC does in fact look at the small groups, but they only do cursory reviews. Mr. Zatkin stated that DOC is going to have limited capacity and manpower to carry these reviews out, which was why recommendation No.6 states that a private sector approach should be established to look at this issue and not leave it to the government to mandate.

Dr. Spurlock had some additional comments and questions regarding this ERG paper. He thought that the discussions on physicians' services and unethical behavior was a bit fuzzy and unclear. He thought that there definitely should be some sort of system to gauge behavior and regulate it. Mr. Hartshorn agreed with Dr. Spurlock's comments but felt that a little more data would be helpful to be absolutely clear on the issue. Dr. Gilbert was concerned that there is no real evidence to demonstrate that adverse outcomes have occurred.

Mr. Shapiro had several recommendations. He first wanted to encourage compensation arrangements that include rewards for quality care and other non-financial factors. Second, he suggested that the federal rule that requires stop loss and surveys be applied to all commercial plans. Mr. Shapiro also pointed out the timing of payment issue that was include in the background materials but not in the recommendations. Mr. Zatkin explained

that the intensity of the incentive increases the more frequently the incentive is calculated – e.g., monthly incentives are more intense than annual incentives.

Chairman Enthoven proposed taking straw polls on the recommendations to see where the members stood:

- Recommendation No. 1 obtained majority support
- Recommendation No. 2 obtained majority support
- Recommendation No. 3 obtained majority support
- Recommendation No. 4(a) obtained majority support with minor changes
- Recommendation No. 4(b) obtained majority support with minor changes
- Recommendation No. 4(c) obtained majority support
- Recommendation No. 5 obtained majority support
- Recommendation No. 6 obtained majority support
- Recommendation No. 7 did not obtain majority support

Dr. Karpf responded to recommendation No. 6 by stating some sort of regulatory body was needed to head up the committees that had been established.

Public Comment:

1) **Maureen O'Haren** – California Association of Health Plans. Ms. O'Haren was cautioned the Task Force members that the federal rules regarding stop loss protection only apply to plans with less than 25,000 covered lives and that the calculations involved are very complex and costly. She suggested a recommendation that the plans either do this calculation or require the stop loss protection. She also suggested that accreditation organizations such as NCQA, rather than purchasers, review plans' incentive arrangements.

2) **Catherine Dodd** – American Nurses Association. Ms. Dodd asked that nursing organizations be represented on blue ribbon panels recommended by the Task Force. She also favored using incentives based on quality.

Ms. O'Sullivan made one last suggestion to add the nurses or their organization to the panels and task force asked for in Recommendation No.6. A straw poll was taken regarding this suggestion and a majority of members supported the proposed amendment.

VII. ADJOURNMENT - 7:08 PM

Chairman Enthoven declared that without any objection, the business meeting would be adjourned. Seeing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Stephanie Kauss, Alice M. Singh, and Teri Shaw